PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on Wednesday, September 12, 2007, 10:00 a.m., at the Department of Public Health, 250 Washington St., Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Ms. Helen R. Caulton-Harris, Mr. Harold Cox, Mr. Paul J. Lanzikos, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Mr. Albert Sherman (arrived at approximately 10:20 a.m.), Dr. Alan C. Woodward and Dr. Barry S. Zuckerman. Absent Members were: Dr. Michèle David, Dr. Muriel Gillick, Dr. Philip C. Nasca, and Dr. Michael Wong, and Also in attendance was Attorney Donna Levin, General Counsel, Department of Public Health.

Chairperson Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance. He further announced that there would be an additional docket item – a presentation on Mosquito Borne Illness (updates on the EEE and West Nile Viruses).

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF JULY 11, 2007:

A record of the Public Health Council Meeting of July 11, 2007 was presented to the Council for approval. A copy of the minutes was distributed to the Council Members prior to the meeting for review. Council Member Dr. Woodward moved for approval. After consideration, upon motion made and duly seconded it was voted unanimously [Council Member Sherman not present to vote] to approve the Record of the Public Health Council Meeting of July 11, 2007 as presented.

PROPOSED REGULATIONS:

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 650.000 (HAZARDOUS SUBSTANCES) TO ESTABLISH A BAN ON TOY LEADED JEWELRY:

Chair Auerbach noted for the record, "…We ask the members of the Council to consider the regulations prior to their being released for public comment and to make any recommendations they like with regard to substance and process."

Ms. Suzanne Condon, Director, accompanied by Ms. Martha Steele, Deputy Director, and Mr. Roy Petre, Senior Policy and Regulatory Advisor, Bureau of Environmental Health, presented the informational briefing on 105 CMR 650.000 to the Council.

Ms. Condon noted that she would cover in today's presentation: public health significance of lead exposure to children, Consumer Product Safety Commission efforts that have been undertaken relative to this issue to date, what her bureau has done in terms of sampling efforts, and looking at jewelry across the state and then concluding remarks.

Ms. Condon stated, “As many of you are aware, children are more vulnerable than adults to the toxic effects of lead. At lower doses, cognitive and behavioral development is impaired. At higher doses, anemia, kidney damage, brain damage, colic and death can occur, and damage suffered from lead poisoning is often non-reversible, and there is wide consensus in the scientific community that blood lead levels exceeding ten micrograms per deciliter is a level of concern. In 2004, the Consumer Product Safety Commission (CPSC) issued a voluntary recall on toy jewelry sold in vending machines across the country and, at that time, our staff was already conducting sampling and analyses of jewelry that we found in vending machines. Unfortunately, despite that recall, we did find jewelry in such machines that contained higher than acceptable levels of lead, despite the recalls. At that time, we chose to work with the retailers where the jewelry was found, notified them in writing of the CPSC recall, and asked that they remove the products from their property. They did indeed do that at that time. However, since that time, CPSC has issued several more recalls. It seems they are almost daily if you look at the news or web, most being recalls on jewelry sold in retail stores targeted to young children.”

Ms. Condon continued, “During the winter and spring of this year, our staff conducted sampling efforts across the state. We took 79 samples in all, and these are some examples of the types of, pictures of products that we were able to find. The Council does have before you a series of the pictures that show what the jewelry looks like, that contained higher levels of lead than we would deem acceptable. We coordinated our efforts with the Department’s State Laboratory and we used the CPSC acid extraction test, to determine the amount of accessible lead for each sample…CPSC has previously devised guidance that suggested that levels greater than 15 micrograms of lead per day, over 15 to 30 days, could result in elevated blood lead levels in children. We believe that exposure period is reasonable for a scenario of swallowing jewelry, as there have been documented cases where jewelry items have stayed in a child’s stomach for as long as 21 days. Additional research shows that on average, when a child swallows a foreign object, it generally stays within their stomach within their system for a period of one to four days. More recently, CPSC devised new guidance of 175 micrograms; they based that on the assumption that this was a short term, one time exposure. However, that assumption does not take into account the much more likely exposure of items staying in a child’s stomach for much longer periods of time.”

Ms. Condon said further, “The result of what we found in our sampling efforts is more than one in ten samples we collected contained detectable levels of lead. All of the samples that contained such levels exceeded CPSC previous exposure criteria of 15 micrograms per day. Eight of the nine exceeded the current CPSC guidance. Our toxicologists also used an EPA Pharmico Kenetic model to evaluate a range of exposures through air, soil or other routes and eight of nine of the samples were predicted by that model to contain enough lead to raise a child’s blood lead level above ten.”

Ms. Condon noted the retailers where jewelry containing detectable lead: “Dollar Fun”, Brockton; “I-Party”, Springfield; “Hey Elvis Dollar Store”, Lowell, “Big Lots”, Lynn;

"Estrella Market", Lawrence; and "Casa Ortiz", Chelsea. She said, "All of these communities are what we deem high risk communities. High risk communities have lower income, older housing stock, elevated blood lead incidences beyond the state rate, and a lower percent of screened children than the Department would like to see."

"What are we proposing for regulations in Massachusetts?" stated Ms. Condon, "We are proposing two criteria. One is similar to the CPSC proposal of no more than 600 hundred parts per million of total lead content by weight in a jewelry piece and the method to that is the screening test for total lead analysis; and also that the product cannot exceed 15 micrograms per day of accessible lead (the extraction test). Why both standards? We think this is important. Available data from Consumer Product Safety Commission showed that many samples that were less than the six hundred parts per million had accessible lead levels that could result in elevated blood levels. Our staff also analyzed CPSC data as well as our own, and when we looked at that. We looked at 108 samples with less than 600 parts per million of total lead content and found that 40% of them exceeded the 15 micrograms per day of accessible lead and limited testing of jewelry with high lead content showed exponentially higher accessible lead levels when the six hour acid extraction test was extended to one to seven days, and that, if you think about the most recent literature that I just mentioned, we think it is very important. In order to minimize lead exposure, we believe both test methods are necessary. We recommend that the 15 micrograms per day standard, instead of the 175 micrograms per day issued by CPSC because we believe it is both more protective and realistic in terms of children's play habits and exposures." Ms. Condon further added, "If a child was to mouth an item that had an unacceptable high level of lead, for no more than one hour a day, for as little as three months, it could result in elevated blood lead levels."

It was noted that the definition of toy jewelry is "Jewelry that is manufactured, shipped or sold at retail or wholesale, indoors or outdoors, over the Internet or through catalogs, and includes, but is not limited to, jewelry sold in vending machines, toy stores or toy displays, toy departments or toy sections, or that may use images or otherwise be designed or packaged to be especially attractive to children." To enforce the regulation, routine spot checking of toy jewelry will be conducted monthly by inspection staff (a certain number of samples monthly for at least one year after promulgation of the regulations). Monitoring will be targeted at high risk communities but also statewide. Any violations will be transmitted to the state Attorney General's Office. The monetary penalties can be up to $5,000 dollars for each article of banned jewelry sold and imprisonment of up to one year is possible under the Hazardous Substance Statute if on at least two separate occasions, a retailer or distributor, or manufacturer sells banned products in Massachusetts.

Ms. Condon noted that her bureau will continue to work with the industry group to notify retailers throughout the state and continue to provide technical assistance to retailers on determining the safety of children's jewelry. She said, "Concurrent with the conduct of the public meetings that will follow after today, we are working on a guidance document so that it will be clear for people who have to comply with these regulations what testing

methodologies must be conducted and what documentation will be necessary for people to sell products in Massachusetts."

Ms. Condon said in conclusion of her presentation, "While the CPSC Safety 2004 Recall has had a degree of success, toy jewelry containing lead is still present in Massachusetts and continues to pose a hazard to children who are exposed to it; and, based upon the points of sale evaluated, Massachusetts children living in high risk communities are the children most likely to be exposed to these jewelry products."

Discussion followed by the Council (for full text please see verbatim transcript of the proceedings). Some of the points made during discussion:

- The current Lead Law in Massachusetts prohibits the application of lead paint being applied to children's toys;
- The proposed regulation is necessary because the jewelry itself, the metal or other parts of the jewelry product contain the lead;
- The proposed regulation intentionally does not define the age of children so that adolescents would be covered under the law;
- The Department hasn't found any solid lead toys on the market; most of the products recalled have been from lead paint;

Council Members Zuckerman and Woodward asked why toys were not included in the proposed law as well as Jewelry. Dr. Woodward's said, "I am wondering if we couldn't make this leaded toys and jewelry because it seems to me we still see little lead trucks and cars, and other things that may not just be lead paint, but there is lead composition. There are other things potentially, that are toys, not jewelry, that kids could swallow, and I also question, you know, there are probably adolescent jewelry that is sold, that has high lead content and, yet the younger siblings gets a hold of it. So, if we were to say leaded toys and jewelry, it would seem to be more expansive, and then you would have the two levels of testing under this act, that would seem to me to be more inclusive, considering what we are seeing, which is sort of one recall after another."

Council Member José Rafael Rivera added, "I am concerned about the limitation of Jewelry. I was thinking about articles of clothing, buttons, belts, things that children can ingest, can mouth, and yet they seem to be not in that group. Are they being addressed somehow, somewhere...What about Internet sales?"

Ms. Condon replied, "I think that under the current Lead Law, for buttons and things like that, if they have lead paint of any kind on them, they are not allowed in Massachusetts. I think that you and Dr. Woodward raise a good point, and I think we will look a little bit more closely at that as we move forward towards a final regulation, so that we ensure that we capture everything to the greatest extent possible." Ms. Condon noted that her monitoring staff purchases items off the internet and tests them also for lead. She said, "We will be looking at each and every outlet that is affected by this, and doing appropriate testing."

Chair Auerbach stated, "…Just following up on a number of comments made, we have, in the past, found it helpful to have specific questions that we ask people to speak to, in consideration of the regulation during the public comment period, and I think that you are hearing that the recommendation of the Council would be that a very specific question would be to the issue of whether the regulation should be broaden to speak to items other than toy jewelry, to include other items of different sizes and different types, and if you could incorporate that into the hearing process, and possibly even think about alternative language, which might capture some of the spirit of their recommendation being made."

Ms. Condon replied, "We will work, as we have, very closely with our Legal Office, to evaluate both what we have with the current Lead Law, as well as these proposed regulations, and make sure that it is comprehensive."

Ms. Helen Caulton Harris, Council Member, noted that she feels this is very important legislation that should be enforced and she would welcome working with state officials on enforcement of the regulations in her City of Springfield, a high risk community. Council Member Mr. Paul Lanzikos, inquired about the burden on distributors and retailers – "What burden would the distributors have to meet?" Ms. Condon indicated that the distributors would have to document that the product itself has no greater than six hundred parts per million of lead and show documentation that they have conducted the acid extraction test (not exceeding 15 micrograms). Ms. Condon said further that the document requirements would be addressed in the guidance document that her department is working on at the moment.

Representative Thomas Stanley added his support for the regulations. Representative Stanley added, "…I am here to applaud the work of the Bureau, and the Department of Public Health. I recognized the need in this area after reading about a four year old child dying in Minnesota two years ago, filed legislation to form a commission to do just this work, review the regulations and statutory laws, and I think this is a great example of our tax dollars really being put to great use. We are really being more proactive than any government in the country and I applaud everyone's effort, and should legislation be required at the end of this, I would be certainly willing to help. I just wanted to support the Public hearing process going forward and really applaud your efforts."

Council Member Lucilia Prates Ramos, asked, "…How do we plan to outreach and educate the consumer, especially those who are residing in Massachusetts high risk communities?..." Ms. Condon answered, "…In Massachusetts, we are fortunate to have the Lead Education Trust Fund. We do have funds available to us for education and outreach. We typically target very heavily the high risk communities. Our Lead staff has done a fantastic job in making all sorts of education informational materials available in many different languages, to suit the needs of the population in particularly the high risk communities." Ms. Condon noted further that they have been already working with the education outreach people in the Lead Program, with the Web site people, the Women, Infant, and Children's Program, and other programs at DPH and other education and early care agencies as the recalls have come out.

In summary, Chair Auerbach stated, "It sounds like the main substantive issue that people would like you to consider in the Public Hearing process is this broadening of the products that would be considered under the regulation. I hear, outside of the regulation, the Council has asked, to pay particular attention, in the monitoring process, to various ways that these products might be sold in distribution outlets or through Internet sales. I also heard concern around partnership with local health and with the general public, in terms of the awareness. When you return, at the end of the public hearing process, if you could perhaps just do an update on some of those specific items, and the ways that those will be incorporated into a roll-out plan." Ms. Condon replied, "Absolutely – will do."

No Vote/Information Only

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 16 DPH REGULATIONS REGARDING FINAL AGENCY DECISIONS IN ADJUDICATORY CASES:

Chair Auerbach began, "As an introduction to this, this proposed regulation was one that I asked the General Counsel's Office to look at and it came in part out of the growing interest of the Council Members in spending more of our meeting times on issues like the ones we were just discussing, and our other major policy issues, with some concern around time for the Council Members. This is one option for consideration of what might free up some of the time during the Council meetings."

Attorney James Ballin, Deputy General Counsel, presented the regulations to the Council. He began with background information, "When the Department of Public Health proposes to take some enforcement action against the individual or business that licenses, it must provide notice in the form of "Notice of Agency Action", which initiates a formal adjudicatory proceeding. Under the administrative rules that govern these proceedings, the Department must notify licensees that they have a right to request an adjudicatory hearing. In addition, as part of that notice, they are notified that, if they fail to submit a timely request for a hearing, they waive the right to a hearing, and they forfeit the right to contest an agency decision. If a timely appeal is filed, the hearing is scheduled. In most cases, that is with the Division of Administrative Law Appeals, also known as DALA. That is an independent agency of the Commonwealth. A Hearing Officer then presides over a hearing and hears evidence presented by both sides and then, ultimately, issues a decision. The formal adjudicatory rules state that the decision rendered by a Hearing Officer after an adjudicatory hearing is considered to be a tentative decision, and agencies must review the tentative decision, and then render a final agency decision."

Attorney Ballin continued, "Since the Department of Public Health is defined by statute as both the Commissioner and the Public Health Council, tentative decisions by DALA have, in the past, been reviewed and approved by the Commissioner and the Public Health Council."

Atty. Ballin described the proposed changes: "The proposed change in each of the sixteen regulations is to delete the requirement that review and approval of tentative

decisions be conducted by the Public Health Council, but continue to have such tentative decisions reviewed and approved by the Commissioner, who would then render a final decision; and, as you can see in the attachment, the language change in each of these sixteen regulations is pretty much identical. In addition to the changes to the regulations, we believe it is necessary for the Public Health Council to formally delegate its authority to the Commissioner for approving final agency decisions in all adjudicatory cases. The reason for this is that only the agency can approve a tentative decision reached by the presiding officer in an adjudicatory hearing, and since the Department is both the Commissioner and the Public Health Council, the Public Health Council must formally agree to delegate its authority to the Commissioner in order to eliminate the Public Health Council review of the tentative decisions."

Atty. Ballin noted and as stated in the staff memorandum to the Council (dated September 12, 2007) the Rationale for the proposed amendments and Request for Delegation of Authority are:

1. The Commissioner is capable of making decisions based on the record in an administrative proceeding and the expertise of the Public Health Council is not necessary to review individual licensing decisions. Prior to making a tentative decision, the Hearing Officer hears all testimony, reviews all documents included in the record, and carefully weighs the evidence in a particular case. Since these cases have already been heard before an impartial hearing officer who has heard all the evidence in the case, it is not necessary for both the Commissioner and the Public Health Council to review all the evidence in the record to reach a final agency decision.

2. Second, similar to previous decisions by the Council to delegate licensing decisions (in 1995), the decision to delegate final agency decision authority in contested cases will provide for greater efficiency and timeliness in reaching a final agency decision and reduce the administrative burden on Department staff. Licensees will retain their rights to appeal any final agency action to the appropriate court.

3. Third, while the number of contested cases appearing before the Council is not large, each case is potentially very time consuming for Council members to review the facts and reach a final decision. Since Commissioner Auerbach has established an ambitious agenda for the Council and given that the Council generally meets only 12 times per year, the delegation of this authority would allow the Council to devote its limited time to the important matters of reviewing and approving regulatory amendments, addressing DoN matters, and guiding the Department on public health policy.

In conclusion, Atty. Ballin noted that a public hearing will be held in October and solicit comments on the proposed regulations. Upon his return, he said he would be asking the Council to take two votes, the first to request final approval to promulgate the

amendments to these 16 regulations and secondly, to formally delegate authority to the Commissioner.

Discussion followed by the Council (please see the verbatim transcript for full discussion):

Council Member Mr. Harold Cox stated, "I have a concern and a suggestion. First, I think that it is a great idea that we are looking for ways of making our work in the Council more efficient, and I am glad that you are considering this. I would also encourage you to think about things like maybe our meetings need to be three hours, as opposed to two hours, in order to cover the long list of things that need to get done…The idea of taking some things off of our responsibilities, also a great way of actually doing that. However, the issue that gets raised for me is this matter of transferring power that what you have here is a regulatory body that has been given responsibility by the Governor and the people to actually review a number of cases, regulations, Determination of Need issues, and the like. The idea of actually transferring power from the Council to the Commissioner is a complicated one, and one that we should take seriously."

Mr. Cox continued, "I am glad to know that there is the extensive process you have for reviewing these cases, and that there is an impartial hearing process, and the like; and, having served as a Commissioner of another community, I certainly understand and appreciate what is involved. I am a little concerned about the issue around precedent that gets set, and while I think that this issue of transferring power is an incredibly important one, at the same time, I also don't want to spend our time also continuing to do things that are the second or third look at a case that really you actually already know the answers to."

Mr. Cox said further, "Here is what I am thinking. I am concerned about the issue of transfer. I believe that it is the right thing to do, but, I would like to not make it permanent. If there is a way for us to consider this regulation, of actually doing this activity, which I actually support, but providing a sunset provision so that we have an opportunity to actually review this in a year or in two years, or some period of time, so that we may actually decide, maybe it is the right thing for this Council to actually be looking at some of these kinds of cases, that would actually make me feel a little bit better. We, as a nation, should be very concerned about issues around transfer of power from regulatory activity. I support it, however, I would like to not make it permanent, and I would like to at least have some consideration and some discussion about that."

It was noted that on average, there are about two cases (Final Agency Decisions in Adjudicatory cases) per year before the Council. The majority being EMT related cases.

Council Member Mr. Paul Lanzikos noted, "I share Mr. Cox's thoughts and recommendations; and, if there is any level of pursuit of his recommendation, I would add a provision that during the time we delegate our authority, that there would be a reporting mechanism, from the Commissioner to the Council, stating that he reviewed

one case or two cases, just so we have awareness that there is some level of activity happening beyond our current purview."

Discussion continued around the issue of delegation of authority to the Commissioner and how the Council can delegate the authority temporarily or revisit the issue in the future. Should it be written into the regulation itself? Should there be a sunset provision or not? Could it be done administratively? The Council decided against the sunset provision because it would trigger another round of public hearings. The Council was open to a process that would not be onerous to the Council or staff.

Chair Auerbach summarized the discussion, "Do the Council Members feel comfortable utilizing the method of identifying particular questions we want to be addressed in the open hearing process: (1) What is the best mechanism for periodically reviewing the appropriateness of the delegation of this responsibility to the Commissioner versus the Council? (2) Is there a mechanism that allows for periodic review? (3) Is there a mechanism that allows for administrative review independent of the question of whether or not the delegation of responsibility is involved, but simply alerting the Council Members to what items have been considered? That may be helpful for them in terms of the overall review, as well." No objections stated.

No Vote/Information Only

REGULATIONS:

REQUEST FOR APPROVAL OF AMENDMENTS TO THE UNIFORM PLUMBING CODE (248 CMR 10.00):

Mr. Howard Wensley, DPH Representative to the State Plumbing Board, presented the amendments to the uniform plumbing code to the Council. He said, "I am the DPH representative to the State Plumbing Board. Most of the members consist of professionals in the field of plumbing or gas fitting. Because of the importance of public health in plumbing, the statute requires DPH to have a seat on that particular board. I fill that particular position. The statute also requires that certain plumbing regulations, once they have been promulgated by the Plumbing Board, also need to be approved by the Massachusetts Department of Public Health. Back in 1996, the statute requiring approval for plumbing regulations in general, was removed and only left one little piece, and I can't figure out why, but it is plumbing related to public buildings. We are here to have the Council approve a plumbing Code change that is already in effect for everybody else except for public buildings, and that particular issue is relative to the lead content of certain plumbing fixtures. Around 1993, the plumbing Board promulgated a regulation which said that no plumbing fixture or pipe could have a lead content of greater than five percent. That was amended, in 1995, down to three percent. Since that time, the federal government EPA has come-up with a different standard that does not speak about the lead content by volume, but relative to leachability of lead into the water; which, after many conversations with DPH and other professionals, was determined it was the better way to go."

Mr. Wensley continued, "For example, if somebody was doing a test for lead content by volume, the result could depend upon where they took the core sample from. They could maybe cut into a piece that has lead, or cut into a piece that doesn't have lead. The current test basically is a Leach A test, and will not allow a lead content greater than eleven parts per million to be leached into the water. Again, this is national standard. It is one that all manufacturers of these products adhere to, and we request that the Council approve this particular provision for public buildings in Massachusetts."

Council Member Dr. Alan Woodward asked if the fundamental exclusion of public buildings could be corrected to eliminate the secondary process of the plumbing board coming before the Public Health Council for approval. Mr. Wenley said it would take legislative action to correct the statute.

Mr. Norm St. Hilair, Acting Executive Director, State Plumbing and Gas Fitting Board stated, "The Plumbing Board is actually looking for the support from the Public Health Council on whether or not they wanted to do that; and so, we can talk to our Board Council and have them present something to legislators to actually amend M.G.L. Ch.142, §12."

Attorney Donna Levin, General Counsel, suggested that Mr. Hilair present the suggestions discussed to his General Counsel and which are (1) delegate to the Commissioner of Public Health in the interim and (2) making a recommendation to the legislature to amend the statute.

Council Member Alan Woodward moved for approval. After consideration, upon motion made, and duly seconded, it was voted unanimously to approve the **Amendments to the Uniform Plumbing Code (248 CMR 10.00)** as presented to the Council in the Memorandum dated September 12, 2007 and accompanying regulation; a copy is attached and made a part of this record as **Exhibit No. 14,888;** and that a copy of the amendment be forwarded to the Secretary of the Commonwealth. This approval adopts NSF/ANSI Standard 61 for public buildings. The NSF/ANSI-61 Standard is a leachability standard. It requires that a plumbing product leach no more than 11 ppb into the potable water carried by that product. The U.S. Environmental Protection Agency's standard for lead in drinking water is 15 ppb or less.

REQUEST FOR PROMULGATION OF AMENDMENTS TO 105 CMR 130.000 (HOSPITAL LICENSURE) FOR HOSPITAL ASSUMPTION OF THE COSTS OF CARDIAC DATA COLLECTION:

Chair Auerbach said in part, "…These regulations were put out for public comment two months ago and Dr. Dreyer is back to relay not only the findings from that public hearing process, but also to offer an example of the benefits of the regulation itself." Dr. Paul Dreyer, Director, Bureau of Health Quality Assurance and Control introduced Dr. Robert A. Phillips, Medical Director, Heart and Vascular Center of Excellence, UMASS

Memorial Medical Center to the Council. Dr. Phillips made a presentation on his program. Some highlights follow:

- Beginning in 2002, the Massachusetts Department of Public Health (MDPH) publicly reported the 30-day mortality rates, by hospital, for isolated coronary artery bypass surgery (known as CABGS). The first report, for calendar year 2002, was released in fall 2004.
- Mortality incident rate for UMass Memorial was 3.58%, while overall state mortality rate was 2.19%.
- UMass Memorial was the highest among the 13 hospitals that perform CABG, but rate was not statistically different than the state average.
- In response to the high mortality incident rate, the Cardiac Surgery Team at UMass Memorial carried out performance improvement project in 2003-2004.
- A steering committee coordinated process improvement teams in several areas.
- Data showed improvement in the use of prophylactic antibiotics, time to extubation after surgery, glycemic control in the postoperative period, and surgical site infection rates.
- However, neither the details of the improvement project, nor the data were shared widely beyond the Division of Cardiac Surgery.
- Worcester Telegram & Gazette Newspaper reported on September 21, 2005 that UMass Memorial had high death rates of about 4% in 2003. The statewide mortality rate was 2.19 percent for 2003. UMass Memorial voluntarily agreed to stop performing elective cardiac surgery while it works with the state Department of Public Health to determine why its mortality rates for bypass operations is higher than at other hospitals in Massachusetts.
- As reported by the Worcester Telegram & Gazette Newspaper, on October 12, 2005: A team of four cardiac surgeons and one cardiac anesthesiologist dispatched by the state Department of Public Health found problems before, during and after surgery, but also described weaknesses in leadership, communication and monitoring of patient outcomes.
- The team spend 80 hours reading records and interviewing hospital staff before issuing 71 recommendations for improvement that would allow the program to reopen.
- As reported in the Telegram & Gazette Newspaper: “We look at these recommendations as an opportunity for the hospital to come to grips with a problem that had been going on for at least since 2002 and to put in place improvements that will result in a better service,” said Paul Dreyer, Director of Health Care Quality at DPH. “That’s everyone’s goal.”
- In 2002, the medical center hired a new chief of cardiac surgery, who subsequently required recruited three additional cardiac surgeons.
- The former, longstanding chief of cardiac surgery, and two cardiac surgeons who were on the medical staff prior to 2002, departed UMass Memorial shortly after the new chief arrived.
- In spring 2005, the chief of cardiac surgery, who was hired in 2002, resigned, as did one of the surgeons he recruited. Three cardiac surgeons remained on the medical staff in the summer of 2005.

- Operational Issues:
  - Pre-op:
    - Case selection: High risk patients were sent to surgery in a system that in retrospect was sub-optimally prepared to manage these cases post-operatively.
  - Intra-op:
    - Anesthesia was not exclusively committed to cardiac cases.
  - Post-op:
    - Lack of cohorting of patients in a specialized post-op cardiac floor
    - Suboptimal cohesiveness of surgical team

- UMass Memorial immediately formed an executive team to lead the improvement project whose members included:
  - Medical Center President, CMO, COO
  - Newly recruited Medial Director of the Heart and Vascular Program
  - The chairs of the departments of surgery and medicine, and two senior vice presidents

- More than 40 physicians and staff participated in the improvement project as members of operational working groups.
- Initiated a rapid cycle process to implement the proposed 71 changes in the program.
- Nearly all aspects of the plan were fully deployed within three months.
- With approval from the MDPH, resumed elective cardiac surgery after a six week hiatus.
- Since 2005, New UMass Memorial Medical CT Surgery Program achieved 8-10 fold reduction in mortality:

Time Period	**Isolated CABG Cases (N)**	**Deaths (N)**	**% Deaths**
2003-2005 (old program)	917	38	4%
2005-Present	>400	2	<0.5%

- New UMass CT Surgery Program Ranks in Top Tier of Society of Thoracic Surgeons (STS) Database:

Time Period	**O/E Mortality**	**Risk-Adjusted Rate**	**Like Group**
2005 (old program)	2.11	4.2%*	n/a
2006 (new program)	0.27	0.5%	1.8%

*Expected Mass-DAC equivalent data

- Superior Performance According to Society of Thoracic Surgeons Database (STS)
    - For 2006 results, 15% of hospitals received the STS "3 star" rating – the highest category of quality
    - UMass Memorial received a 3-star rating for 2006 results from STS

- **Why was UMass successful – Transparency**
    - Senior leadership accepted accountability for the crisis, stated that the mortality rates were too high, and made a public commitment to fix the problem;
    - Senior leaders met with medical staff, employees, referring physicians, and the board of trustees on a regular basis to explain the causes of the problems and to report progress on improvements to the cardiac surgery program;
    - Humility: "The Day a Physician Loses his humility is the day that physician becomes a menace to society" by Richard Gorlin, M.D.;
    - Humility:
        - Outside experts provided an objective analysis that we would have had difficulty performing ourselves
        - We entered a contractual relationship with the Massachusetts General Hospital (MGH) to provide two senior cardiac surgeons on site (Drs. Vandersalm and Daggett);
        - These physicians provided day-to-day supervision and ongoing assessment of the program for a period of five months.
    - Outstanding New Leadership – Dr. Lynn Harrison in January 2006
        - He built a strong team of three surgeons and led the implementation of changes in the program.
        - Dr. Harrison optimized teamwork and improved morale among all members of the cardiac surgery team
        - His focus on continuous improvement have been critical in assuring ongoing success of the program

In closing, Dr. Phillips stated, "The cardiac surgery crisis was a catalyst for changing the broader oversight and execution of quality and patient safety at UMass Memorial. It led to great changes within the entire system at UMass. Memorial." Dr. Phillips noted further that UMass Medical center has broken into the top ten, number 9, among the eighty-two academic medical centers rank by the University Health Systems Consortium, a clearinghouse for quality.

Chair Auerbach noted, "This is a wonderful success story and we appreciate your frankness in terms of discussing it with us…What we really wanted to do is focus on how the regulation that is before us is useful in terms of creating an environment where we

can identify problems and correct them, with UMass being one example of how that was successfully done."

Dr. Paul Dreyer, Director, Bureau of Quality Assurance and Control, added, "UMass was the first outlier that we identified in the second year in which we publicly released the data that is collected pursuant to the regulations that are before you. When we saw that UMass was in fact a statistical outlier, we realized that an action was necessary and we collaboratively engaged in the process that you have just seen outlined. The regulations before you today have been through the public hearing process. We received testimony from three organizations, from Partners Healthcare, which testified on behalf of the three Partners hospitals performing cardiac surgery; that is the Brigham, Mass. General, and North Shore Medical Center; from UMass Memorial, which recounted the story that you have just heard today, and from the Massachusetts Hospital Association, which testified that its members were committed to meeting the licensure regulations as well, as working with the Department's data vendor to provide timely and appropriate information on the services. The Massachusetts Hospital Association made some specific suggestions with respect to streamlining some of the data reporting requirements, which we have addressed by essentially agreeing to remove those data reporting requirements into an administrative bulletin, which was probably where they belonged in any case. We had a number of specific details about how the data would be collected and reported, and the time lines about those activities. We are going to move those to an administrative bullet, which is consistent with what we have done with subsequent data reporting regulations regarding stroke. We are asking the Council's promulgation of these regulations today."

Council Member Albert Sherman moved approval of the regulation. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the **Promulgation of Amendments to 105 CMR 130.000 (Hospital Licensure) for Hospital Assumption of the Costs of Cardiac Data Collection**; that a copy be attached and made a part of this record as **Exhibit No. 14, 889**; and that a copy be forwarded to the Secretary of the Commonwealth.

Council Member Sherman noted for that record that he had no conflict of interest on this regulation. UMass Memorial and the University of Massachusetts Medical School are separate legal entities since 1997 and further that he derives no income from the hospital. Chair Auerbach added that it has been determined that no Council Members with hospital affiliations have any conflicts of interest with regards to voting on this regulation.

MISCELLANEOUS:

REQUEST FOR DELEGATION OF AUTHORITY TO THE COMMISSIONER FROM THE PUBLIC HEALTH COUNCIL FOR APPROVAL AND AMENDMENT OF PUBLIC HEALTH HOSPITAL BYLAWS:

Attorney Steve Chilian, Deputy General Counsel, Department of Public Health, presented the request for approval and amendment of the Public Health Hospital Bylaws. He said,

"…The matter before the Council is a request by the Department that the Council delegate authority for approving and amending the bylaws governing departments for Public Health hospitals. Those hospitals are the Lemuel Shattuck Hospital, Tewksbury Hospital, Mass. Hospital School, and Western Massachusetts Hospital. The Bylaws set-up the structure for the Department's management and oversight of the hospitals. Included among its provisions is the requirement that amendments for the bylaws be approved by the Council. Requested amendments to the bylaws that would periodically come before the Council generally involve routine housekeeping matters such as periodic updating to ensure that bylaws continue to comply with conditions of participation issued by CMS and with Joint Commission standards. By delegating the authority to approve and amend the hospital's bylaws to the Commissioner, the Department seeks to create a more efficient and flexible amendment process for the revision of the hospitals' bylaws, a process that will allow both the Council and the Department to best utilize their time and resources."

Chair Auerbach clarified, "This is a new body that was created just a few years ago, and we met for the first time since I have been Commissioner, and immediately identified the need to do such things as alter the subcommittee structure to deal with changing some of the composition of the board. I mean, relatively routine matters, and we were unable to make any of those changes because all those changes would require our bringing those matters before the Council because of the way that the bylaws had been drafted two years ago. I actually think it was probably an error that they were drafted in that way because we didn't think that the Council, even the previous Council, would want to get involved in the question of whether a subcommittee should be created to deal with an identified issue on the Board, or not; and so, we thought that we should bring that before you for review. And again, if it is the decision of the Council to have those matters brought to you, we would absolutely have no problem with doing that. It is just that they are the kind of routine matters that sometimes seem not to rise to the level of requiring the Council's attention."

Council Member Mr. Cox said, "This feels different to me than the last issue. The last issue was about looking at responses to cases. The matter of bylaws, and personally I run from bylaws. I don't want to be ever on bylaws committees, but the idea of actually reviewing the bylaws for any entities frightens me, scares me, bores me, and I would actually feel differently about this one than I did about the last one. I actually have no problem."

Council Member Mr. Cox made the motion for approval. After consideration upon motion made and duly seconded, it was voted unanimously to approve the request for **Delegation of Authority to the Commissioner from the Public Health Council for Approval and Amendment of Public Health Hospital Bylaws**.

PRESENTATION: ACTIONS STEPS TO RESPOND TO THE LEHMAN CENTER REPORT ON THE REDUCTION OF HOSPITAL ACQUIRED INFECTIONS", By Paula Griswold, Coalition for the Prevention of Medical Errors,

Laurie Kunches, JSI Research and Training Institute, and Dr. Paul Dreyer, Director, Bureau of Quality Assurance and Control:

Chair Auerbach made introductory remarks about the presentation to follow. He said in part, "…I am sure you remember the incredibly impressive proposal that was made by Nancy Ridley at our last Council meeting with regard to the report that was prepared by the Betsy Lehman Center on the issue of hospital-acquired infections. Ms. Ridley presented that for informational purposes…I think it is safe to say, enormous enthusiasm on the part of the Council Members, for following through on the recommendations that were coming through, coming out of the Lehman Center. We wanted to follow-up on that clear enthusiasm on your part by presenting to you specific action steps that will be taken to implement the recommendations from the Lehman Report. Some of those action steps involve contract dollars and planned initiatives. One of them involves the proposal of a regulation…"

Ms. Laurie Kunches, Director of Clinical Research, JSI Research and Training Institute, a not-for-profit public health consultant group. Ms. Kunches noted that there are four goals that have been set forth in this campaign for the Department…I will be addressing Goals 1 and 4, the first being to complete the work of the Lehman Center and the Expert Panel and the fourth educational activities for the public and consumers. Although you saw a fairly lengthy report, there is still much more to be done. Paula Griswold will talk about Goal 2 and Dr. Paul Dreyer on Goal 3.

Ms. Kunches continued, "In the first interim report that was released, we covered a number of best practice recommendations in the area of prevention, and this is the work that is remaining to be completed. We have accomplished a lot and those of you who work in the field understand that this is somewhat of a moving target. For example, we already had our task groups reviewing the precautions and, since that time, CDC this summer released an update of those precautions. So, we constantly have to update our evidence and bring the experts back to the most recent statements for their review. We are reconvening the panel in September. We expect to have monthly meetings through January. We have six task groups that work through conference calls, and they are resuming work next week. The main points that are remaining to be completed involve these prevention guidelines particularly around bloodstream surgical site infections, as well as the control of MRSA or methicillin resistant staphoreus and other resistant pathogens. We will be then taking these statements, which are mainly for adult patients, and revising them as needed for pediatric populations, and this is somewhat of a challenge because there is not a lot of literature that relates specifically to children and neonates; and, finally, there is a group that is working on some standards for infection control programs because, believe it or not, there really are not well established standards in that regard. We are also looking at options for how to deal with the data in terms of risk adjustment, and the presentation you just heard explains why that is important. We are looking at, in fact, working with a consultant that is part of the current MASS-DAC program; and finally, we are expecting to provide guidance to the Coalition for Prevention of Medical Errors, in the work that they will be doing in disseminating these

best practices to the hospitals, both in helping them identify the most important topics and the right faculty."

Paula Griswold, Coalition for the Prevention of Medical Errors, stated, "We will be serving as a subcontractor, receiving funding from the Department of Public Health through JSI for a set of activities that will help support hospitals in their improvement efforts in reducing infection rates. The Massachusetts Coalition for the Prevention of Medical Errors is a not-for-profit, multi-stakeholder organization of groups that share the common goal of improving patient safety. I also had the privilege of serving on the State's Expert Panel on Hospital Acquired Infections. The Coalition has some experience with working with hospitals in this sort of learning collaborative setting. We worked with the Department of Public Health, the Betsy Lehman Center, and in collaboration with the Hospital Association on two topics, one in medication safety, and one in communicating critical test results, where we successfully recruited, at least 90% of the state's acute care hospitals to participate. They formed improvement teams, and when we evaluated those programs at the end of the project, more than 90% of the hospital CEO and team leaders said that that learning collaborative had been instrumental in their succeeding in making improvements. We want to bring that experience to this topic for four categories of infections over the next nine to ten months. We have this set of activities to help support hospitals with their improvement work. First, we could engage hospital leadership, reaching out to encourage them, ask them to designate an improvement team to sign-up for the project, ask that they continue to review the results that the improvement team is producing and help support the team's successful efforts and remove barriers that they are experiencing within the hospital. The project would also centrally keep in touch with hospital leadership and essentially share success strategies of how do leaders help their teams have success."

Ms. Griswold continued, "We would form our own improvement advisory group, following up on the activities of the Expert panel, would include hospital representatives for quality improvement, infection control, clinical leaders, and then other outside experts, obviously, including the Department of Public Health, the Lehman Center, and some members of the Expert panel. During that period of time, we would commit to having at least three statewide educational programs where the teams would have the chance to hear from experts, get resources, get ideas from colleagues, share their own lessons learned and then, also, have the expectation that they would be reporting back to colleagues, so people know they need to make progress, to come back and report at those sessions. As part of the project, we would look for resources from national models and Massachusetts programs that have had success, turn those into tool kits so that each hospital team doesn't have to reinvent the wheel. There is a lot that exists already. We would have people put in front of them what has been done elsewhere so they could customize it, utilize it, and help improve it in their own settings."

Ms. Griswold noted other support services that will be provided through their project director:

- Review brief monthly reports from hospitals. Use these reports to find out what interventions have been made and what they learned. In the reports ask the hospitals to share their latest data points to see who had great breakthroughs that could be shared and the report would identify those having some trouble and that might need additional consultation.
- Conduct regular conference calls with national experts about various topics and the interventions that supported improvement.
- Maintain a Statewide list for the teams to be able to consult with each other on a regular basis. It also keeps it on the front burner and helps keep the team active on the topics. Onsite visits by Paula, project director and other teams. This allows the teams to learn from one another.
- Develop strategies and materials that could be used to activate patients and families to actively participate in their care.

Ms. Kunches noted that for Goal 4, they are working with UMASS, where researchers are testing some approaches to conveying this information to the public. "We are currently in discussions about the best approaches for educating the public with a number of outside groups, including the Coalition, and how to coordinate these activities."

Dr. Paul Dreyer, Director, Bureau of Quality Assurance and Control, noted, "Goal 3 is about mandatory reporting and oversight. Mandatory reporting will require a regulation. The regulation will require hospitals to report selected outcome measures to the National HealthCare Safety Network (NHSN) in three Tiers. One Tier will be a set of measures that the Department will turn into a public report, very similar to what we have described for cardiac surgery. The Second Tier will give the Betsy Lehman access to data that is not quite ready for public reporting. These will be elements where there may be risk adjustment issues that need to be resolved. In the second Tier, we will have the opportunity to work with the data, with the hope that we will be able to transition it to data that can be in fact, publicly reported. In the Third Tier are elements which are not ready even for the Betsy Lehman Center. We want hospitals to look at their own data so that they can compare themselves to other hospitals. These are items where definitions aren't clear, where there may be widely disparate ways that hospitals are defining things, where the state of the art, it just is not ready for a more refined reporting."

Tier One – Publicly Reported Elements

- SSI for Hip and Knee Replacement
- BSI central venous catheters in ICUs (pathogens)
- Health care worker immunization rates: influenza vaccine (pending)

Tier Two – Betsy Lehman Elements

- BSI for central venous catheter in ICUs (skin contaminants)
- SSI for CABG
- VAP head elevation; MRSA point prevalence

Tier Three – Elements for use in Internal QA only

- BSI central venous catheter outside ICUs (pathogens & skin contaminants
- VAP rates

Dr. Dreyer further noted, "Basically what we will be doing is requiring hospitals to report all of these data to the NHSN. What is kind of neat about the NHSN is it is a database that allows access by rule. So, in other words, each Tier will be accessible only to certain folks….We think we know how to write these regulations and are hopeful that we will come back to the Council in November with them. For the oversight piece, what we would like to do is incorporate the Expert panel best practices into our current regulations. It is not so easy to do. We might add provisions for educating patients about their role in preventing infections. In addition, we have funding to hire new surveyors, with a focus on infection control, to make site visits. Initially, their role will be assistive and consultative, and what will happen is, we would expect that role to transition over time to a more regulatory focus. They will be resources to go to hospitals to help, to make sure that they are all on board with this program, that they are incorporating the best practices into their current system, working out issues, working with the Coalition and its efforts. I expect that they will be attending Coalition meetings and then they will transition into a regulatory role."

Chair Auerbach stated, "Again, the work that Ms. Kunches and Ms. Griswold described is work that has begun already, and will continue over the next few months, and we will ask them to give us periodic reports on their progress if possible. The philosophy behind this is that it is essential that we prevent hospital acquired infections and that we want to use a variety of different approaches in terms of preventing those infections. One approach is working aggressively with the hospitals, in collaboration, to give them the tools, to give them the expertise, to give them the support, so that these changes can immediately begin to be put into effect, and best practices already in effect can be highlighted, that we can immediately begin to work with patients around educating them, providing them with tools which allow them to be part of the process, for improving the safety matters; and at the same time, that we think about this being one with mandatory regulations, where we are able to look at how hospitals are doing comparatively to each other, as well as, not only in terms of bad outcomes, but in terms of taking appropriate preventive steps and there will be process – some of these processes that have been mentioned, will be looking at whether or not there are, in fact, good measures, essential measures that the hospitals are engaged in, to try to avoid the infections occurring unnecessarily, that we just then compare hospital to hospital, but to eliminate the infections, or drive them down to the lowest possible amount by doing a variety of different approaches."

A brief discussion followed by the Council. Council Member Mr. José Rafael Rivera inquired about the tool kits. He said, "Referring to Goal Two, the issue of the tool kit for families and consumers about becoming partners, it is very clear that the current cultural,

ethnic and religious groups have different views on what that means, and I hope the tools reflect that, as opposed to one tool translated into different languages, or one tool fitting for all." Council Member Mr. Paul Lanzikos, asked about migrating the lessons learned and best practices to other health care settings. Ms. Griswold responded that they have been working with the Massachusetts Extended Care Federation with anticipation of carrying the lessons and best practices into the long term care settings and the continuum of care for orthopedic surgery. Dr. Dreyer further responded, "We started with hospitals, but our plan is to move to other settings and long term care and post acute care hospitals will be the logical next steps. Dr. Alan Woodward, Council Member asked that he hoped the Expert Panel planned on including influenza immunization monitoring in their program. Ms. Laurie Kunches replied, "Yes, we expect them too."

Chair Auerbach concluding the discussion with these remarks, "Thank you all, and may I say that part of this effort is, there is a confluence of activities, I think, that are drawing attention to the importance of minimizing, if not eliminating, hospital acquired infections. A lot of different groups are working on this issue. There was mention earlier of the work around consumer and patient education, and the coalition. We have worked with other groups that are doing very important work on this issue and hope to work in collaboration with them. I will also mention in the same vein, there is state legislation that is under consideration, also, to address the issue of eliminating hospital acquired infections. There in fact, ironically, is a hearing that is going on today, which Ms. Prates and I will both be participating in, and I am sure many other people will, as well. We feel we are developing these approaches, these regulatory approaches in sync with the intent of the legislators who are focused on this issue, such as Senator Moore, to draw more attention to the issue of hospital acquired infections, and to take aggressive action in terms of trying to eliminate this risk."

No Vote/Information Only

NEW BUSINESS: PRESENTATION: MOSQUITO BORNE ILLNESS BY Dr. Alfred DeMaria, Director, Bureau of Communicable Disease Control and Dr. Mary Gilchrist, Director, State Laboratory Institute:

Chair Auerbach made introductory remarks, introducing Dr. DeMaria and Dr. Gilchrist.

Dr. DeMaria said in part, "…It is a pleasure to be able to report what is, for this season, good news. We are not out of the woods yet, and we still have, unfortunately, time where mosquito borne infection could still be transmitted; but; as we get into the cooler weather, the risk definitely goes down, and this year was very different from last year, where we experienced considerable numbers of EEE and West Nile Virus cases, and what we would like to do is just sort of compare and contrast last year to this year. This year also saw the arrival of Dr. Gilchrist as the Director of the Laboratory and that personally contributed to a better summer for me."

He continued, "…I think the most important difference from last year is this year was a much more proactive versus reactive year in terms of mosquito borne illness, and there

are a number of reasons. One was very strong support from Central Office DPH, in terms of being able to do things we haven't done in the past, in terms of mobilizing local public health in a more effective way, and doing more with public relations, public service announcements, and other activities, as well as the fact that we were sort of galvanized by both the experience of the last three years, with thirteen Eastern Equine Encephalitis cases and the response to that, and the leadership of people who were impacted on a personal and family level by the experience with EEE in the past few years."

Dr. DeMaria continued, "We have also been very fortunate, over a number of years, to have a surveillance program, an arbovirus surveillance program at the State Laboratory, in the Laboratory Bureau, ably led by Cindy Stinson who has done a perfect job of mobilizing, and I am also very happy to report that Matthew Osborne, who is the Field Director for that program, is now one of our Pride in Performance recipients for 2007, a well-deserved recognition for somebody who has done an outstanding job of doing the field work. Looking at a comparison of West Nile Virus activity this year to last year, there really isn't a substantial difference, except we have had three human cases diagnosed in Massachusetts, one in a Massachusetts resident, but all three of them acquired their infection out of state. Although it is unfortunate there are three people who were diagnosed with West Nile virus, only one is a Massachusetts resident, and none of them acquired their infection in Massachusetts."

"In terms of dead bird testing and mosquito testing", said DeMaria, "We are running a little behind last year, and a lot of that has to do with the dry weather. We haven't had a drought this year, but we have had below usual levels of rainfall, and that is particularly important with West Nile Virus in terms of the mosquitoes that transmit West Nile Virus – the culex mosquitoes that reproduce in puddles, in pools, and water collections on property, and we have been vigorous in our recommendations to reduce those, and the weather has helped."

In closing, Dr. DeMaria stated, "…These mosquitoes can continue to reproduce as long as the weather is warm. We are still concerned about West Nile Virus, but the other thing we have observed this year is that West Nile Virus intensity has actually been in the same areas of the EEE intensity, and also those areas that have gotten the most concentrated prevention messages, in terms of reduction of mosquito exposure and mosquito numbers. In terms of Eastern Equine Encephalitis, the numbers of mosquito collections that are positive are way down over last year and, again, the water levels have been down. The most intensive area of decreased rainfall actually has been in the southeastern part of the state, where EEE is most frequent and the mosquito collection are down, as you can see in the chart. Despite that, we do feel that there is a significant EEE risk in the southeast, in the traditional EEE areas, in Northern Bristol and Plymouth counties, as well as along the New Hampshire border. As you know, New Hampshire has reported two EEE cases this year."

Dr. Mary Gilchrist, Director, State Laboratory Institute, "I arrive here in the May/June time period and I was off and running. The first days, I was with Commissioner

Auerbach and Dr. DeMaria at the State House, working with the legislators and the State Mosquito Reclamation Board, which consists of Conservation and Agriculture, and Environmental Protection, trying to solidify on a program to keep things from getting out of hand this summer. We were obviously hoping that this would burn-out, and so we don't know if we can take credit for what has happened so far, but certainly, as this stage, I am very pleased with where we are. The lab is a very excellent lab. I can't take very much credit for the history of the lab, but you have to realize that this laboratory probably is the absolute premier laboratory for EEE, and that is because they have a long history. They understand and know what to do with this disease and how to detect it. They have historical data. You need to retain that wonderful operation because, if you lost it, you can't put it back together again. It's gone. It doesn't come back together at all easily. I don't take credit for any of that. I am just pleased to be here helping with it, and we have PCR, which is a fancy genetic testing to find the disease in mosquitoes, the virus in mosquitoes very early, within a few hours after the mosquitoes are submitted to us, and I think you need to really celebrate what you have here. It is a wonderful operation. It is run very efficiently. You get really rapid results compared to a lot of other places."

In conclusion she said, "I just want to say that this is a great place to be working, that we will never be perfect. The testing relies on collections in specific places. People have to protect themselves. They have to wear a repellent. They have to avoid mosquito seasons as much as they can, but we do the best we can to tell people where the greatest risks are and when they appear. That's my message."

A brief discussion followed (see verbatim transcript for full text). Council Member Lanzikos asked about the national experience. Dr. DeMaria replied in part, "…The West Nile Virus has involved the entire country, and there are areas where, because of the particular species of mosquitoes that are involved, it has a very intense and prolonged experience. We expect to see cycles of West Nile Virus and so far, we haven't had enough experience to know that. I would say, for West Nile Virus, we are sort of in low ebb, in terms of the impact it has right now, although, we remain concerned about it, and the potential there is for it to come back with a vengeance and we are always on the lookout for that. EEE is much more limited in where it occurs and it really only occurs in parts of the country that have a particular ecologic niche for it, and that is the White Cedar, and Red Maple swamp lands. It occurs along the Eastern Seaboard, and into the North Central States, and those areas, we definitely see a cycle to EEE, and that cycle is probably based on several factors…"

Council Member Ms. Helen Caulton-Harris noted her appreciation to Dr. DeMaria for his work with the local boards of health in assuring that they have the information they need to deal with West Nile, and in particular, when the first bird that tested positive for West Nile Virus was found in Springfield.

No Vote/Information Only

The Meeting adjourned at 12:20 P.M.

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John Auerbach, Chair

LMH/lmh